State of Idaho Emergency Medical Services Bureau

Provider Application Form

Level Applied For: ☐ First Responder ☐ EMT-Basic ☐ Advanced EMT-A ($35.00 fee) ☐ EMT-Paramedic ($35.00 fee)

Type: ☐ Initial ☐ Recertification ($25.00 fee for AEMT-A and EMT-P) ☐ Reinstatement ☐ Reversion ☐ Ambulance Rating (complete back) ☐ Reciprocity

Applicant Information:

Social Security # _____ - ____ - _____ Date of Birth ____ / ____ / ____ Drivers License # _____ DL State ____

Name _____ Gender ☐ F ☐ M

Last Name First Name Middle Name/Initial

Mailing Address _____

City _____ State _____ Zip _____ County _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____ Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8

Affiliation:

Agency Name _____ Agency License # _____

Agency Chief/Director/President _____ _____

Signature Printed Name

Additional Licensed EMS Affiliations: _____

Check all circumstances in which you will use this certification: *Volunteer* *Career*

☐ True ☐ Full Time

☐ Compensated ☐ Part Time

Applicant Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS certification as established by the State of Idaho.

_____ _____

Signature of Applicant Date signed

For Bureau Use Only

Received in RO Complete

Received in C&L Complete

CHC Scan Date (PROV) _____

CHC Complete Date (FULL) _____

Course # _____

NR Written Date _____

NR Practical Date _____

Ambulance Rating (if AEMTA)

Date _____ Included ☐

Cert. Fee Rcvd Date_____

Approval Date/Initial _____

Entered into Database _____

_____

Date Sent to CO _____

Previous ID State Certification ☐

_____

First Responder/Basic

Test Date	Expiration
4/03-9/03	9/30/2006
10/03-3/04	3/31/2007
4/04-9/04	9/30/2007
10/04-3/05	3/31/2008
4/05-9/05	9/30/2008
10/05-3/06	3/31/2009
4/06-9/06	9/30/3009
10/06-3/07	3/31/2010
4/07-9/07	9/30/2010
10/07-3/08	3/31/2011
4/08-9/08	9/30/2011

Advanced, Intermediate and Paramedic

Test Date	Expiration
4/04-9/04	9/30/2006
10/04-3/05	3/31/2007
4/05-9/05	9/30/2007
10/05-3/06	3/31/2008
4/06-9/06	9/30/2008
10/06-3/07	3/31/2009
4/07-9/07	9/30/2009
10/07-3/08	3/31/2010
4/08-9/08	9/30/2010

EMT-AMBULANCE RATING REQUEST

Applicant Name:_____ EMS Provider Number:_____

I hereby verify the applicant named on this form has completed twenty-five (25) patient contacts under the supervision of a preceptor certified at the EMT-Basic level with an Ambulance rating or higher certification, between the dates of _____ and _____.

Patient contacts are defined as those encounters consisting of a complete patient assessment or being the primary medical care provider for the duration of on-scene intervention or transport.

_____ _____

Signature of Agency Medical Director or Designee Agency Name

_____

Printed Name of Agency Medical Director or Designee

Revised 09/01/2006